HEALTH HISTORY FORM

Please Print Neatly or Type

1. Name: _____ 2. SS Number: _____

3. Date of Birth: _____ 4. Phone: _____

5. Mailing Address: _____

_____

6. Past and Present Personal Health History (check if appropriate)

____ Disease of arteries and heart
____ Diabetes or abnormal blood sugar
____ High Blood pressure
____ Angina (chest pain)
____ Epilepsy
____ Stroke
____ Anemia
____ Abnormal chest X-ray
____ Cancer
____ Asthma
____ Other lung disease
____ Orthopedic or muscular problems

If any are checked, please explain further and indicate any recommendations your doctor has made regarding exercise. _____

_____

_____

7. Level of Physical Activity

Yes ___ No ___ Are you currently involved in a regular exercise program such as walking, swimming, cycling, or jogging?

Yes ___ No ___ Do you regularly walk or run one or more miles continuously?
If YES, average number of miles you cover per workout: _____
What is your average time per mile: _____

Yes ___ No ___ Do you practice weight lifting or calisthenics?

Yes ___ No ___ Do you perform stretching exercises on a regular basis?

8. Is there a family history of heart disease, hypertension, stroke, diabetes, lung disease, or epilepsy? _____ Yes _____ No

If YES, please provide information regarding who the relative is, the medical problem, and the age at onset or death: _____

_____

_____

9. Yes _____No ___ Do you currently smoke cigarettes?
If YES, how many cigarettes per day? _____
If you smoked in the past, when did you quite? _____

10. Yes ___ No ___ Are currently taking medication prescribed by a physician?
If YES, indicate name of medication, dosage taken, and month and year you began taking it. _____

_____

_____

11. Please indicate below any additional medical information that you think is important for us to know prior to fitness testing or exercises.

_____

_____

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PARQ)

1. Name: _____ 2. SS Number: _____

A simple screening tool used to identify individuals who probably should not be tested in a field setting without physician clearance.

YES	NO	
___	___	1. Has your doctor ever said you have heart trouble?
___	___	2. Do you frequently have pain in your heart or chest?
___	___	3. Do you often suffer from severe dizziness?
___	___	4. Do you have any orthopedic problem such as arthritis that might be aggravated by exercise?
___	___	5. Is there a good reason not mentioned here why you could not follow an exercise program even if you wanted to?
___	___	6. Are you over age 65 and <u>not</u> accustomed to vigorous exercise?
___	___	7. Have you ever been told by a doctor that your blood pressure was too high?
___	___	8. Are you currently using any prescribed medications?
___	___	9. Are you pregnant?

ASSESSMENT SHEET
Raw Scores

Name _____

Age _____

Weight _____

ASSESSMENT	PRE TEST	POST TEST	
Resting Heart Rate			(beats/min.)
Resting Blood Pressure			(SBP mmHg/DBP mmHg)
Step Test			(steps/min.)
% Body Fat			(%)
1 Minute Sit-up			(number)
Push-up			(number)
Sit and Reach			(inches)
Bench Press			(pounds)
Leg Press			(pounds)
1.5 Mile Run			(time)
12 Minute Walk			(distance)

Name _____

FITNESS PROFILE

Flexibility Sit & Reach	Cardiovascular Step 12 Min. 1.5	Dynamic Strength **Push-up/Bench Press**	Dynamic Strength Sit-up	BC % Fat
Superior				
Excellent				
Good				
Fair				
Poor				
Very Poor				

Fitness Area	**Tests**	**Raw Score**	**Fitness Level**
Flexibility	Sit & Reach	_____	_____
Cardiovascular	3 Min. Step Test	_____	_____
Cardiovascular	12 Min. Run/Walk	_____	_____
Cardiovascular	1.5 Mile Run	_____	_____
Dynamic Strength	Push-up/Bench Press	_____	_____
Dynamic Strength	Sit-up	_____	_____
Body Composition	Skinfolds	_____	_____